Application Form for the Statewide/Federal Deafblind Census

(Use this form for suspected or confirmed deafblindness)

Student Information

First Name _____ Last Name _____

Date of Birth _____ Gender ☐ Male ☐ Female

School District of Residence _____ County of Residence _____

School/Agency Student Currently Attends _____

School District Student Attends _____

Hearing Loss
☐ Confirmed
☐ Suspected

Vision Loss
☐ Confirmed
☐ Suspected

Contact Person Information

First Name _____ Last Name _____

CESA Closest to School/Agency _____

Title _____

Phone _____

School/Agency _____

Fax _____

Street Address _____

City _____ State _____ Zip _____

E-Mail Address _____

Parent Information

Instructions: If parents have the *same address, use only Parent 1 section*. If there are two separate addresses (e.g., parents separated or divorced), use both sections. Please notify parents and obtain *permission to share their information*.

Parent 1 First Name(s) _____ Last Name _____

Street Address _____

City _____ State _____ Zip _____

Phone _____ Cell _____

E-Mail Address _____

Parent 2 First Name(s) _____ Last Name _____

Street Address _____

City _____ State _____ Zip _____

Phone _____ Cell _____

E-Mail Address _____

Please fax completed form to: Joan Wheeler at (608) 356-0091
Mail to: Joan Wheeler, WDBTAP Office Associate, 124 2nd Street, Suite 35, Baraboo, WI 53913